



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SOUTH TEXAS RADIOLOGY GROUP  
PO BOX 29407  
SAN ANTONIO, TX 78229-5907

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

54

#### **MFDR Tracking Number**

M4-12-2480-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We were given Ohio Casualty Group at time services were rendered. It was not until 11/22/2011 that we received patients workers compensation information. Per TDI-DWC Rule §133.20 we had 95 days from the time we were notified of Workers Compensation Insurance to file this claim."

**Amount in Dispute:** \$26.74

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor provided radiology services to the claimant 8/23/11. Texas Mutual received the bill on 12/7/11. (Attachment) The requestor's explanation for the lateness of the bill does not meet the criteria for untimely bill submission in the Labor Code 408.0272."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
08/23/2011	73110, 73090	\$26.74	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of Workers' Compensation

Specific Services provided on or after March 1, 2008.

5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 12/16/2011

- CAC-29- The time limit for filing has expired
- 731-Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service for services on or after 9/1/05

Explanation of benefits dated 02/15/2011

- CAC-193-Original payment decision is being maintained upon review, it was determined that this claim was processed properly
- CAC-29- The time limit for filing has expired.
- 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824
- 731-Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service for services on or after 9/1/05

### **Issues**

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided." Review of requestor's documentation finds a position statement which states that they were given Ohio Casualty Group as the insurer at time services were rendered, therefore billed Ohio Casualty Group on 09/02/2011. However, no documentation was provided in accordance with 408.0272(b)(1) to support that the requestor billed Ohio Casualty Group within 95 days from the date services were provided. No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

_____	_____	04/30/2012
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**